Audit Report

FOLLOWUP AUDIT OF THE EUROPEAN THEATER
C-9A AIRCRAFT FLYING HOUR PROGRAM

Report Number 99-147 May 5, 1999

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Acronyms

AE	Aeromedical Evacuation
FHP	Flying Hour Program
USAFE	U.S. Air Forces in Europe

INSPECTOR GENERAL
DEPARTMENT OF DEFENSE
400 ARMY NAVY DRIVE
ARLINGTON, VIRGINIA 22202-2884

May 5, 1999

MEMORANDUM FOR UNDER SECRETARY OF DEFENSE (COMPTROLLER)
ASSISTANT SECRETARY OF DEFENSE (HEALTH AFFAIRS)
ASSISTANT SECRETARY OF THE AIR FORCE (FINANCIAL MANAGEMENT AND COMPTROLLER)

SUBJECT: Report on the Followup Audit of the European Theater C-9A Aircraft Flying Hour Program (Report No. 99-147)

We are providing this report for review and comment. We performed the audit at the request of the Assistant Secretary of Defense (Health Affairs) and the Office of the Air Force Surgeon General and as a followup to Inspector General, DoD, Report No. 97-192, "European Theater C-9A Aircraft Flying Hour Program," July 18, 1997. We considered comments on a draft of this report from the Assistant Secretary of Defense (Health Affairs) and the Air Force Surgeon General in preparing the final report.

DoD Directive 7650.3 requires that all recommendations and potential monetary benefits be resolved promptly. As a result of management comments regarding the transfer of funding, we revised Recommendation 1. to the Assistant Secretary of Defense (Health Affairs), added Recommendation 2. to the Under Secretary of Defense (Comptroller), and renumbered draft Recommendation 2. as Recommendation 3. in this final report. We request that the Assistant Secretary of Defense (Health Affairs) provide additional comments on Recommendation 1., the Under Secretary of Defense (Comptroller) comment on Recommendation 2., and the Air Force provide additional comments on Recommendation 3. All comments should be received by July 6, 1999.

We appreciate the courtesies extended to the audit staff. Questions on the audit should be directed to Mr. Michael A. Joseph at (757) 766-9108 (mjoseph@dodig.osd.mil) or Mr. Michael A. Yourey at (757) 766-3268 (myourey@dodig.osd.mil). See Appendix D for the report distribution. Audit team members are listed inside the back cover.

David K. Steensma

David K. Steensma
Deputy Assistant Inspector General
for Auditing

Office of the Inspector General, DoD

Report No. 99-147 **May 5, 1999**
(Project No. 8LF-5019)

Followup Audit of the European Theater C-9A Aircraft Flying Hour Program

Executive Summary

Introduction. The audit was performed at the request of the Assistant Secretary of Defense (Health Affairs) and the Office of the Air Force Surgeon General and as a followup to Inspector General, DoD, Report No. 97-192, "European Theater C-9A Aircraft Flying Hour Program," July 18, 1997. In the prior audit, we recommended that U.S. Air Forces in Europe establish a flying hour program of 4,100 hours and reduce its staffing levels to 12.5 air crews. We also recommended that the Assistant Secretary of Defense (Health Affairs) reduce the C-9A flying hour reimbursement to the Air Force by $3 million annually. The Air Force agreed to reduce the flying hour program to 4,960 hours and agreed to reduce staffing levels to 12.5 air crews. The Assistant Secretary of Defense (Health Affairs) agreed to adjust the reimbursement based on a flying hour program of 4,960 hours in FY 1998.

U.S. Air Forces in Europe, the air component of the U.S. European Command, manages the aeromedical evacuation system in Europe. The 86th Airlift Wing of U.S. Air Forces in Europe, located at Ramstein Air Base, Germany, provides aeromedical transportation for patients in the European theater using C-9A aircraft. In FY 1998, DoD spent about $23.5 million ($10.9 million of Defense Health Program appropriations and $12.6 million of Air Force Military Personnel appropriations) to transport 7,570 patients and attendants on C-9A aircraft in the European theater.

Objectives. The audit objective was to review the flying hour program to determine the flying hours required, considering a redefined mission for the C-9A aircraft and the flying hours necessary to meet air crew training requirements. We followed up on recommendations in Inspector General, DoD, Report No. 97-192. We did not review the management control program as it relates to the overall audit objective because controls related to the aeromedical evacuation program were covered in Inspector General, DoD, Report No. 95-225, "Aeromedical Evacuation System," June 9, 1995.

Results. Since our last audit, the U.S. European Command reorganized the Theater Patient Movement Requirements Center and increased the effectiveness and efficiency of its personnel and record keeping. However, the U.S. Air Forces in Europe flying hour program of 4,960 hours exceeded training and peacetime movement requirements by 710 hours. Over the 6 years of the FYs 2000 through 2005 Future Years Defense Program, DoD can use $8.58 million ($1.43 million of Defense Health Program appropriations in FY 2000 and $7.15 million of Air Force Operation and Maintenance appropriations FYs 2001 through 2005) for other valid health care requirements by reducing the flying hour program to 4,250 flying hours. For details of the audit results, see the Finding section.

Summary of Recommendations. We recommend that the Assistant Secretary of Defense (Health Affairs) reduce the FY 2000 reimbursement to the Air Force for the European theater C-9A flying hour program. Additionally, we recommend that the Under Secretary of Defense (Comptroller) reduce the FYs 2001 through 2005 Operation and Maintenance appropriations to the Air Force for the European theater C-9A flying hour program. We also recommend that the Commander, U.S. Air Forces in Europe, reduce the flying hour program for the C-9A.

Management Comments. The Assistant Secretary of Defense (Health Affairs) nonconcurred with reducing the C-9A flying hour program reimbursement to the Air Force in the European theater by $1.43 million. The Assistant Secretary stated that cost savings were overstated because the hourly rate used in estimating benefits included logistics costs that must be paid whether the plane flies or not. Additionally, reducing the flying hours could result in increased temporary duty and lost duty time costs. Finally, the Assistant Secretary stated that benefits should not be calculated over 6 years because a Program Decision Memorandum moves the funding for C-9A operations from the Defense Health Program to Air Force Operation and Maintenance appropriations. The Air Force disagreed with reducing the C-9A flying hour program, stating that the reduction could have devastating long-term effects on the peacetime medical care system and wartime medical readiness posture. The Air Force further stated that it ran the Composite Absorption Analysis Model using the same assumptions used by the Inspector General and determined that 12.5 air crews would require 5,250 flying hours. A discussion of management comments is in the Finding section of the report and the complete text is in the Management Comments section of the report.

Audit Response. We consider the Assistant Secretary of Defense (Health Affairs) and the Air Force comments to be nonresponsive to the recommendations. The estimated benefits of $1.43 million annually are not overstated and are based on calculations using hourly rates similar to those previously agreed to by the Office of the Assistant Secretary in response to two previous C-9A flying hour reports. The flying hour rate proposed by the Assistant Secretary would not cover the cost of fuel, much less any maintenance costs. As stated in the report, increased costs related to temporary duty or lost duty time should be minimal. Finally, transferring funds from the Defense Health Program to the Air Force does not mean that benefits will not accrue for 6 years; it means that benefits may accrue to a different appropriation. Accordingly, we revised the recommendation to the Assistant Secretary to cover only that period for which the C-9A operations will be funded from the Defense Health Program, and added a recommendation to the Under Secretary of Defense (Comptroller) to reduce the reimbursement to the Air Force after the transfer of funds. We disagree with the Air Force contention that reducing the flying hour program will have devastating impacts on the peacetime medical care system and wartime medical readiness posture. As shown in the report, 4,250 flying hours would allow DoD to satisfy its peacetime medical care requirements and adequately train its pilots. Not all assumptions used by the Air Force were consistent with those used by the Inspector General when it applied the Composite Absorption Analysis Model and calculated flying hours required to train C-9A air crews. We applied the 35 hours to inexperienced pilots (using a pilot ratio of 35 inexperienced to 65 experienced) as we had in Reports No. 97-143 and No. 97-192. That is the same ratio the Air Force applied to its continental United States C-9A flying hour program. Further, the Assistant Secretary and the Air Force did not address TRICARE as an alternative to the aeromedical evacuation flights, even though DoD is presenting TRICARE as one of the cornerstones of the Defense Health Program. We request that the Assistant Secretary of Defense, the Air Force and the Under Secretary of Defense (Comptroller) provide comments by July 6, 1999.

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Background

Aeromedical Evacuation Mission. The mission of the aeromedical evacuation (AE) system is established in DoD Regulation 4515.13-R, "Air Transportation Eligibility," October 1995. The primary mission of the AE system in the European theater is to transport U.S. military casualties from the combat zone to fixed or field hospitals as required. During peacetime, the AE system provides air crews and medical crews with required training and transports active duty and retired personnel, and their dependents, to medical treatment facilities within the European theater.

AE System in European Theater. In 1992, the Secretary of Defense established the U.S. Transportation Command as the single manager for transportation functions. U.S. Air Forces in Europe (USAFE), a major command of the U.S. Air Force at Ramstein Air Base, Germany, manages the AE system in the European theater. USAFE is the air component of the U.S. European Command and the U.S, component of the North Atlantic Treaty Organization. The 86th Airlift Wing of USAFE, located at Ramstein Air Base, has four C-9A aircraft to support the AE system. The C-9A is a commercial DC-9 aircraft configured as a flying hospital ward, capable of carrying up to 40 patients in litters or seats. Within the 86th Airlift Wing, the 75th Airlift Squadron and the 86th AE Squadron coordinate to support the AE mission in the European theater. The 75th Airlift Squadron provides active duty air crews, while the 86th AE Squadron provides active duty medical crews. The Command Surgeon at USAFE centrally manages the flying hour program (FHP) and is responsible for medical care provided in 83 countries from Albania to Zimbabwe, to include diplomatic tasking and military operations other than war. The C-9A aircraft are flown primarily within the European theater; they do not transport patients to the continental United States.

C-9A Routine Missions. As of April 1998, USAFE flew 13 routine missions to 15 locations from Ramstein Air Base on a weekly basis. Routine missions provide patients with transportation to medical treatment facilities on a scheduled airline route within Europe and the Middle East. Of the 13 routine missions, 10 are one-way missions providing service to Azores, Bosnia, Crete, Egypt, England, Italy, Sardinia, Saudi Arabia, Sicily, Spain, and Turkey. For example, mission 10T3 provides transportation from Ramstein, Germany, to Aviano, Italy, and Cigli and Incirlik, Turkey, on Saturday. It returns to Ramstein on Sunday as mission 10T4, providing return service to patients. Mission 10T5 originates in Ramstein Air Base and services Aviano, Cigli, and Incirlik on Wednesday. On Thursday, the mission originates as mission 10T6 in Incirlik and services Cigli; Souda Bay, Crete; and Sigonella, Sicily, ending at Ramstein Air Base. The remaining three missions provide round-trip service to Bosnia, England, Italy, and Sicily. Military personnel who do not need medical care are also allowed to fly on C-9A aircraft as space-available passengers. See Appendix C for the April 27, 1998, European C-9A schedule of routine missions by destination and mission number.

Patient Transportation. In FY 1997, USAFE transported 7,570 patients on C-9A aircraft within the European theater. Approximately 17 percent, or 1,272, of the patients transported were inpatients; the remaining 83 percent, or 6,298, were outpatients. Patient transfers by type of beneficiary and patient category are shown in Table 1.

Table 1. C-9A USAFE Patient Transfers in FY 1997

Beneficiary	Inpatient	Outpatient	Total
Active Duty			
Army	162	800	962
Navy	498	1,262	1,760
Air Force	205	1,294	1,499
Marine Corps	39	52	91
Coast Guard	6	0	6
Subtotal	**910**	**3,408**	**4,318**
Non-Active Duty			
Dependent of active duty	238	2,215	2,453
Retired	56	422	478
Dependent of retired	28	152	180
Others	40	101	141
Subtotal	**362**	**2,890**	**3,252**
Total	**1,272**	**6,298**	**7,570**

The AE system also transported 269 patient attendants (110 medical attendants and 159 nonmedical attendants).

Prior Audit Report. Inspector General, DoD, Report No. 97-192, "European Theater C-9A Aircraft Flying Hour Program," July 18, 1997, reported that European theater C-9A AE aircraft were flown in excess of requirements. In addition, air crew staffing exceeded levels needed to maximize C-9A flying time. The report stated that USAFE based the FHP on historical performance and staffing, rather than on the hours needed to satisfy training and peacetime AE requirements. The report stated that over 6 years, $18.0 million of Defense Health Program and $2.1 million Air Force Military Personnel appropriations could be put to better use by reducing the FHP from 5,560 hours to 4,100 hours and reducing the number of air crews from 14.5 to 12.5. Accordingly, the Air Force agreed to reduce the FHP to 4,960 hours, a 600-hour reduction, and agreed to reduce staffing to 12.5 air crews. The Air Force attributed the 860-hour difference (4,960 minus 4,100) to a redefined mission for the C-9A aircraft and the flying hours necessary to meet air crew training requirements.

Accordingly, the Assistant Secretary of Defense (Health Affairs) reduced the reimbursement to the Air Force by $7.4 million over 6 years to reflect the 600 hour reduction.

Redefined Mission. In May 1997, USAFE redefined the AE mission by adding a routine C-9A mission to Tuzla, Bosnia. According to USAFE officials, the commander of the Bosnia area of operation took the C-130 aircraft stationed at USAFE headquarters off alert status, because it was too costly. The C-130 was used for other purposes than aeromedical evacuation. Keeping it on alert cost the Bosnia command about $8,000 per day. Adding the C-9A mission to alert status and adding a weekly mission to Bosnia, instead of keeping the C-130 on alert, shifted alert costs from the commander of the Bosnia area of operation to the USAFE Command Surgeon. As with other users of the AE system, the Bosnia commander is not charged for AE service provided by USAFE. Because of special training requirements associated with flying into the Bosnia area of operation, USAFE established a weekly routine mission to Bosnia. Flying the Bosnia mission adds about 150 flying hours annually. In August 1997, the Assistant Secretary of Defense (Health Affairs) and Office of the Air Force Surgeon General requested the Inspector General, DoD, to validate the impact of the redefined mission on the European FHP.

Objectives

The overall audit objective was to review the FHP to determine the flying hours required, considering a redefined mission for the C-9A aircraft and the flying hours necessary to meet air crew training requirements. We did not review the management control program as it relates to the overall audit objective because controls related to the AE system were covered in Inspector General, DoD, Report No. 95-225, "Aeromedical Evacuation System," June 9, 1995. See Appendix A for a discussion of the scope and methodology. See Appendix B for a summary of prior coverage.

European Theater Flying Hour Program

The FY 1998 FHP for the C-9A aircraft exceeded training and mission requirements. This occurred because USAFE based its FHP on flying routine missions, rather than on the flying hours needed to satisfy training and AE mission requirements. By reducing the FHP to 4,250 hours, DoD could put $8.6 million to better use over FYs 2000 through 2005.

FHP Necessary for Patient Requirements

The FY 1998 FHP of 4,960 hours, as developed by USAFE, exceeded training and mission requirements by about 710 hours. USAFE based its FHP on flying routine missions that were not required and were not the most effective and efficient method of transporting patients within the European theater. Using the Air Force Composite Absorption Analysis Model and analyzing aircraft occupancy rates, we determined that USAFE could have satisfied training requirements and redefined mission requirements with 4,250 hours in FY 1998. The 4,250-hour FHP would also have satisfied the requirement for transporting patients within the European theater during peacetime.

Training Requirements. The USAFE needed an FHP of 4,100 hours in FY 1998 to train 12.5 C-9A authorized air crews and four staff and supervisory pilots. Training requirements for C-9A air crew and staff and supervisory pilots had not changed since our prior audit report, issued in July 1997. The 4,100 hours was based on the Composite Absorption Analysis Model developed by the Air Force. The model includes variables such as a pilot-to-copilot ratio and an average tour of duty. In July 1998, Air Mobility Command officials stated that no changes had occurred to the Composite Absorption Analysis Model that would impact the 75th Airlift Squadron's training requirements.

Redefined Mission. The added Tuzla mission required about 150 flying hours. Although the 150 flying hours could be accomplished within the 4,100 hours required for training purposes, we recognize the unique demands of the European theater and, accordingly, added the 150 hours to the 4,100-hour training requirement for an FHP of 4,250 hours. The 150 hours could be reduced from future FHPs if the Bosnia mission is discontinued, but recognizing the unique demands of the European theater, we did not recommend such a reduction. We believe that USAFE can effectively and efficiently accomplish its training mission and transport patients in peacetime within the 4,250-hour FHP.

C-9A Aircraft Occupancy Rates. Patient and attendant occupancy on many of the routine flights was far less than capacity. We judgmentally selected and analyzed flight occupancy for 150 of 624 routine flights flown during the period April 1997 through March 1998. The 150 flights had an average patient and attendant occupancy rate of 24 percent. Table 2 shows the C-9A aircraft occupancy by mission for the 150 flights. See Appendix C for the April 1998 schedule of routine missions.

Table 2. Patient and Attendant Occupancy by Mission for 150 Sampled Flights
(April 1997 through March 1998)

Mission Number	Flights Reviewed	Seats Occupied	Seats Available	Percent Occupied
1057	12	516	1,768	29.19
1061	12	569	1,912	29.76
1062	12	350	1,704	20.54
1063	12	291	1,560	18.65
1064	12	572	1,868	30.62
1065	12	244	1,396	17.48
1066	2	89	296	30.07
10S3	13	73	848	8.61
10S4	13	171	728	23.49
10T3	13	386	1,416	27.26
10T4	14	481	1,528	31.48
10T5	15	252	1,544	16.32
10T6	8	157	956	16.42
Total	**150**	**4,151**	**17,524**	**23.69**

To determine the occupancy rate for each mission, we compared the cumulative number of patients and attendants (both medical and nonmedical attendants) transported and the cumulative number of seats on board the aircraft for all legs of the mission. Space-available passengers are not included in patient and attendant occupancy calculations. We adjusted the number of seats on board the aircraft to allow for litters (a stretcher to carry sick or wounded patients, which uses four regular seats). Table 2 shows that none of the missions had an occupancy rate greater than 32 percent, and 5 of the 13 missions had occupancy rates less than 20 percent. During the prior audit, we performed a similar analysis for 99 flights flown during the period October 1995 through August 1996. It showed USAFE had a patient and attendant occupancy rate of about 26 percent.

Passenger Categories. We also looked at passenger categories in our sample of 150 flights. Table 3 shows that 59 percent of the passengers transported were space-available passengers, traveling for nonmedical reasons. Under the space-available program, active duty personnel (on leave), their dependents, military retirees, and their dependents are authorized to occupy DoD aircraft seats that are surplus after all space-required passengers have been accommodated. In addition, Table 3 shows that less than 1 percent of total passengers were urgent or priority patients and that only an additional 31 percent required any type of medical treatment.

Table 3. Passenger Category on Sampled Flights

Category	Number of Passengers	Percent of Passengers
Patient attendants	526	9.3
Priority or urgent patients	12	0.2
Routine patients	1,752	31.1
Space-available passengers	3,345	59.4
Total	**5,635**	

Alternatives to Flying Routine Missions. USAFE can reduce its FHP by 710 hours without compromising patient care. Discontinuing or reducing the frequency of low-occupancy routine missions and low-occupancy flights and using other military flights and commercial air service should reduce flying hours needed for transporting patients. In addition, as TRICARE is implemented in Europe, the demand for AE should decrease.

Routine Missions. USAFE can achieve much of the 710-hour reduction by eliminating unneeded missions. For example, USAFE flies four missions (missions 10T3, 10T4, 10T5, and 10T6) to and from Turkey (two round-trips). USAFE could achieve a 582-hour reduction by eliminating missions 10T5 and 10T6. During April 1997 through March 1998, patient and attendant occupancy on 23 flights averaged 16 percent. Of the 197 patients transported on the 23 flights, 1 patient was urgent and 1 patient was priority. We believe USAFE could eliminate one of the two weekly round-trip routine missions to Turkey and still provide the same level of care to beneficiaries.

Low-Occupancy Flights. USAFE could save additional flying hours by canceling routine flights when only a few routine patients require transportation. For example, in our sample of 150 flights, we identified 29 flights with 10 or fewer routine patients on board. Of the 29 flights, 14 flew with 5 or fewer routine patients on board. None of the 29 flights transported priority or urgent patients. According to USAFE officials, they cancel scheduled flights when there are no patients requiring transportation.

Other Military Flights. USAFE could further reduce the C-9A FHP by using existing flights of other military aircraft to transport routine patients to and from Ramstein Air Base. Military aircraft, such as KC-135, C-5, C-141, L-10, C-130, and KC-10, fly into 7 of 15 locations currently serviced by C-9A aircraft. Table 4 shows the locations and frequency of military flights.

Table 4. Locations Serviced by Other Ramstein Air Base Military Aircraft

Location	Round-Trips Per Week
Lajes, Azores	2
Tuzla, Bosnia	7
Mildenhall, England	4
Aviano, Italy	5
Naples, Italy	1
Sigonella, Sicily	1
Incirlik, Turkey	3

From March 1997 through April 1998, 102 patients were transported on military flights other than C-9A AE.

Commercial Flights. By using commercial flights when other military flights are not available, USAFE could further reduce the C-9A FHP hours. Commercial flights cost less than flying routine C-9A missions with low occupancy. For example, as shown in Table 5, USAFE could fly up to 16 routine patients from Turkey round-trip to Ramstein Air Base (via Frankfurt, Germany, airport), by taking the highest published commercial fare as of August 28, 1998, without exceeding the cost of a C-9A flight. In making this comparison, we used the Air Force standard composite hourly rate for flying C-9A aircraft. Table 5 compares the cost of selected C-9A routine missions to the cost of commercial flights. Table 5 also shows the number of passengers who would have to fly commercially before exceeding the cost of flying the routine mission (the break-even point).

Table 5. Comparison of C-9A Cost to Commercial Cost

Round-trip Mission	C-9A Cost	Commercial Cost per Passenger	Break-even Point (No. of Passengers)
1057	$10,261	$ 968	10
10T3/10T4	20,120	1,258	15
10T5/10T6	22,534	1,351	16

Commercial transportation should only be used when necessary, after other alternatives have been exhausted. The reduction in routine missions and flights and using available military aircraft should accommodate most of the proposed FHP reduction. Therefore, we believe that reliance on commercial transportation would be minimal.

TRICARE Services in Europe. As TRICARE is more fully implemented in Europe, the need for C-9A AE should decrease. TRICARE Europe became operational in October 1997. It is modeled after the TRICARE program in the United States, and also provides additional services unique to the overseas environment. Each beneficiary is assigned a primary care manager

responsible for managing the health care needs of the individual. Most locations covered by C-9A routine missions have established TRICARE services, including England, Greece, Italy, and Turkey. As more comprehensive care and primary care managers become available in the near future, the need for the AE system to transport routine patients to major regional medical centers will decrease because beneficiaries will be able to obtain medical care where they are stationed.

Effect of Reducing Flying Hours

Reducing the FHP to 4,250 hours would allow the Assistant Secretary of Defense (Health Affairs) to reduce its reimbursement for C-9A aircraft from Defense Health Program appropriations to the Air Force by $1.43 million for FY 2000. Additionally, beginning in FY 2001 it will allow the Under Secretary of Defense (Comptroller) to reduce funding to the Air Force Operation and Maintenance appropriations by up to $1.43 annually or $7.15 million over the FYs 2001 through 2005 Future Years Defense Program. The estimated cost reductions were based on the hourly rate used by the Assistant Secretary of Defense (Health Affairs) to fund the FHP, which includes amounts for contractor logistics support, fuel, and other support costs. The estimate was not reduced to cover the cost of transporting patients by commercial aircraft because we believe such use would be minimal.

Recommendations, Management Comments, and Audit Response

Revised, Redirected, Added, and Renumbered Recommendations. As a result of management comments regarding the transfer of funding for C-9A operations, we revised Recommendation 1., added Recommendation 2., and renumbered draft Recommendation 2. as Recommendation 3.

Beginning in FY 2001, funding for the C-9A operations will be transferred to the Air Force. Consequently, we revised Recommendation 1. to the Assistant Secretary of Defense (Health Affairs) to cover just FY 2000. Additionally, we added Recommendation 2. to the Under Secretary of Defense (Comptroller) to reduce the transfer of funds to the Air Force Operation and Maintenance appropriations in FYs 2001 through 2005. Because the management comments were received too late to impact FY 1999, the recommendations address FYs 2000 through 2005 rather than FYs 1999 through 2004.

1. We recommend that the Assistant Secretary of Defense (Health Affairs) reduce the C-9A flying hour reimbursement to the Air Force by $1.43 million in FY 2000 and use the funds for other valid health care needs.

Assistant Secretary of Defense (Health Affairs) Comments. The Assistant Secretary nonconcurred with reducing the C-9A FHP reimbursement to the Air Force in the European theater by $1.43 million annually. The Assistant

Secretary stated that the audit team used the rate of $2,018 per flying hour, which includes logistics costs whether the C-9A aircraft flies or not, to calculate estimated savings and not the more appropriate rate of $807 per flying hour. Using the $807 rate generates annual cost savings of only $573,000, not $1.43 million. The Assistant Secretary also stated that a reduction in flying hours could lead to increased temporary duty costs and lost duty time, further reducing cost savings. Additionally, a Program Decision Memorandum that moves funding for the C-9A aircraft operations from the Defense Health Program to the Air Force in FY 2001 means that the cost savings should be calculated over 2 years instead of over 6 years, making the reported cost savings insignificant.

Audit Response. The comments from the Assistant Secretary were not responsive. The rate of $807 per hour proposed by the Assistant Secretary does not fully cover the cost of jet fuel, much less any maintenance costs associated with the flying hours. We would welcome the opportunity to review the support for the $807 per hour estimate, however, none was provided. The C-9A fuel costs were about $911 per flying hour in FY 1998 according to Air Force cost and planning documents. We used the FY 1998 DoD hourly reimbursement rate of $2,012 for this report. In the Inspector General, DoD, Report No. 97-192, the Assistant Secretary agreed to reduce the reimbursement to the Air Force for the same European theater using a rate of $2,054 per flying hour and reduced the FY 1998 reimbursement to the Air Force accordingly. The Assistant Secretary provided no rationale for the change in position on the hourly rate. The Assistant Secretary also agreed with a similar calculation and recommendation in Inspector General, DoD, Report No. 97-143, "Followup Audit of the Aeromedical Evacuation System," May 19, 1997, to reduce the reimbursement for C-9A operations in the continental United States. We determined the $2,054 flying rate by calculating only those costs directly related to flying hours. We excluded all maintenance and other costs that were time-phased and not related to flying hours. For this report, we used the DoD reimbursement rate of $2,012 because it was more conservative than the rate of $2,054 per hour agreed to in the prior reports.

We considered temporary duty costs and lost duty time in estimating the potential monetary benefits associated with the reduced FHP. However, we did not include those costs in the report because they were insignificant when compared to the total costs associated with the C-9A FHP. For example, eliminating one of the two Turkey missions, as identified in our report, would have impacted only 178 of the 2,278 routine patients and attendants for the sampled period April 1997 through March 1998. Temporary duty costs and lost duty time could actually decrease as a result of patients and medical attendants taking other military and commercial flights, or using TRICARE Europe.

Transferring funding for C-9A aircraft operations to the Air Force in FY 2001 does not mean that potential monetary benefits should be calculated for only 2 years. Benefits will accrue for the lifetime of the FHP reduction, regardless of whether they will occur in the Defense Health Program or in the Air Force Operation and Maintenance appropriations. We typically limit our calculations to the 6 year Future Years Defense Program. Consequently, a reduced FHP

should be considered in calculating the funds to be transferred to the Air Force in FY 2001. We request that the Assistant Secretary reconsider her position on the recommendation and provide additional comments in response to the final report.

Air Force Comments. The Air Force also nonconcurred with the recommendation. The Air Force stated that we overestimated the potential savings of reducing the C-9A FHP by 710 hours, because we used the DoD reimbursable rate of $2,018 per hour that included sunk costs, instead of a more accurate variable rate of $800 per flying hour. Further, the Air Force stated that the Inspector General, DoD, failed to consider other costs associated with the AE transportation system, such as member's temporary duty, lost duty time, and commercial transportation costs. The Air Force also stated that significantly reducing the FHP would shift costs from the FHP to European Command military treatment facilities or the member's unit. As a result, the military treatment facility or active duty member's unit will either incur additional temporary duty costs or an increase in lost duty time. Further, the 710-flying hour reduction, which includes eliminating or decreasing routine missions to Turkey and Italy, would increase temporary duty expenses by $284,000 annually, and reduce the overall Defense Health Program savings to $1.7 million over 6 years. The Air Force also stated that the auditors ignored in their projected savings the Program Decision Memorandum that moves Defense Health Program funding for C-9A operations to Air Force Operation and Maintenance appropriations in FY 2001. As a result, the total estimated Defense Health Program savings would be at the most $425,000. Including the cost of alternative transportation and lost duty time, there would be no savings.

Audit Response. We disagree with the Air Force comments for the same reasons discussed in our response to the comments from the Assistant Secretary of Defense (Health Affairs). Additionally, we question how the Air Force estimated the $284,000 of annual increase to temporary duty costs. No support or details were provided for the estimate. We determined for our sample period from April 1997 through March 1998, that only 178 of the 2,278 patients and attendants would have been affected by eliminating one of the two Turkey missions. Assuming that patients and medical attendants would have waited for the next available AE flight, an additional $34,000 in temporary duty costs would have been incurred. However, if those individuals flew on other military and commercial flights, or used TRICARE Europe, the temporary duty costs and lost duty time could have decreased. It is interesting that the Assistant Secretary and the Air Force did not address TRICARE as an alternative to AE flights, even though DoD is presenting TRICARE as one of the cornerstones of the Defense Health Program. Commercial air costs should be negligible because using commercial flights was suggested as a last alternative. Analyzing passenger statistics of C-9A flights in Europe shows that the majority of passengers on the C-9A were space-available passengers. As shown in Table 3 of our report (page 6), only 12 of 5,635 passengers were patients requiring priority or urgent care, 1,752 were patients requiring routine care, and 3,345 were space-available passengers.

2. We recommend the Under Secretary of Defense (Comptroller) reduce the C-9A flying hour reimbursement to the Air Force Operation and Maintenance appropriation by $1.43 million annually ($7.15 million for the FYs 2001 through 2005 of the Future Years Defense Program).

3. We recommend the Commander, U.S. Air Forces in Europe, establish a flying hour program of 4,250 hours for the C-9A aeromedical evacuation aircraft.

Air Force Comments. The Air Force nonconcurred and recommended no reduction of flying hours for the European theater C-9A flying hour program. The Air Force stated the reduction could degrade quality of life and expressed concern that a 710-flying hour reduction could have devastating long-term effects on the peacetime medical care system and wartime medical readiness posture. Additionally, the Air Force stated it ran the Composite Absorption Analysis Model as of January 14, 1999, and calculated that 12.5 air crews would require 5,250 flying hours a year, 290 flying hours more than the Air Force FY 1998 FHP of 4,960 flying hours. The Air Force also requested that the auditors validate their numbers using the Composite Absorption Analysis Model. The Air Force stated that in July 1998, the Air Mobility Command official who is responsible for the Composite Absorption Analysis Model was on temporary duty and, therefore, could not validate the report statement that there is no impact to the 75th Airlift Squadron training requirements.

Audit Response. The comments from the Air Force were not responsive. We disagree with the Air Force contention that reducing the flying hour program will have devastating impacts on the peacetime medical care system and wartime medical readiness posture. The report showed that 4,250 flying hours would allow DoD to satisfy its peacetime medical care requirements and adequately train its pilots. As shown in Table 2 of the report (page 5), the FHP was inefficient because only 4,151 seats of the 17,524 total available seats were used for medical patients and attendants. Further, as shown in Table 3 (page 6), 59.4 percent of 5,635 passengers were space-available passengers. As discussed in the following paragraph, we believe the C-9A FHP of 4,250 hours more than adequately satisfies training requirements in Europe.

A 4,250-hour FHP for the 12.5 air crews will fully satisfy Air Force training requirements. The Air Force calculated the total of 5,250 flying hours based on 35 flying hours per month per pilot and did not consider the inexperienced-to-experienced pilot ratio. In determining the FHP, we applied the same methodology the Air Force used for its continental United States C-9A FHP, and that we used in the prior follow-on audit of the continental United States AE program and the first audit of the European theater C-9A FHP. Further, in July 1998, Air Mobility Command officials confirmed that they had not changed the way they calculated flying hours for C-9A air crews. It is unclear why the Air Force used a different methodology to calculate the flying hours required for C9-A air crews based in the European theater. In the absence of any details, we remain convinced that the recommended 4,250 hours will provide sufficient flying hours to meet Air Force training requirements.

Further, the 5,250 flying hours is 290 hours more than the FY 1998 FHP and the FHP agreed to by the Air Force in our prior audit of the European C-9A AE program.

In July 1998, Inspector General, DoD, auditors visited the Air Mobility Command, Directorate of Operations, to validate the Composite Absorption Analysis Model. On July 7 and 8, 1998, we met with Air Mobility Command officials responsible for calculating C-9A flying hours required for training. During that visit, even though the Air Mobility Command official responsible for the Composite Absorption Analysis Model was on temporary duty, we communicated with him through e-mail messages. Air Mobility Command officials assured the auditors that neither the Composite Absorption Analysis Model nor the methodology used to calculate required flying hours had changed since our prior audit of the continental United States-based C-9A AE program.

Assistant Secretary (Health Affairs) Comments. The Assistant Secretary also disagreed with the recommendation to establish an FHP of 4,250 hours. The Assistant Secretary stated that we did not accurately calculate training requirements using the Composite Absorption Analysis Model and that the Air Mobility Command had identified the true training requirements as 35 flying hours per month per pilot (12.5 air crews), for an FHP of 5,250 hours, or 1,000 more flying hours than identified in the report.

Audit Response. We disagree with the Assistant Secretary comments for the same reasons discussed in our response to the Air Force comments. The Assistant Secretary agreed with similar calculations in three prior reports on the C-9A AE FHP.

Appendix A. Audit Process

Scope

We reviewed and revalidated the USAFE C-9A FHP, considering the redefined mission for the C-9A aircraft and the flying hours necessary to meet air crew training requirements. We evaluated the FY 1998 FHP for C-9A aircraft that was managed by USAFE and funded by Defense Health Program appropriations ($10.9 million) and Air Force Military Personnel appropriations ($12.6 million). We reviewed contingency plans as of May 1998 supporting the need for four C-9A aircraft based in Europe. We also verified that the Air Force Composite Absorption Analysis Model had not been changed since our prior audit. We considered alternatives for transporting patients on the C-9A aircraft, including other available military aircraft and commercial air transportation. We obtained information as of September 1998 on TRICARE Europe and obtained reports on health care services provided to military beneficiaries and future TRICARE Europe plans. In addition, we reviewed AE files, including patient manifests, for 150 routine flights that the 75th Airlift Squadron performed from April 1997 through March 1998. We reviewed the Automated Patient Evacuation System reports and identified the number of patients transported in FY 1997. We obtained information on the availability of commercial flights for the locations routinely serviced by the C-9A aircraft and obtained published airfares from the web site Travelocity, as of August 28, 1998. We reviewed manpower documents, dated June 1998, that authorized the C-9A air crews, and we evaluated air crew staffing levels that were needed to meet training requirements. We held discussions with cognizant officials on the operational capability requirements and role of the C-9A aircraft related to changes in mission requirements.

DoD-Wide Corporate Level Goals. In response to the Government Performance and Results Act, DoD has established 6 DoD-wide corporate level performance objectives and 14 goals for meeting these objectives. This report pertains to achievement of the following objective and goal.

> **Objective:** Maintain highly ready joint forces to perform the full spectrum of military activities. **Goal:** Maintain high military personnel and unit readiness. **(DoD 5.1)**

DoD Functional Area Reform Goals. Most major DoD functional areas have also established performance improvement reform objectives and goals. This report pertains to achievement of the following functional area objective and goal.

Health Care Functional Area. Objective: Ensure joint medical readiness capabilities. **Goal:** Ensure doctrinally sound, operationally integrated, joint medical force capable of successfully meeting health service demands throughout continuum of military operations. **(MHS-1.2)**

Methodology

We reviewed the FY 1998 FHP that included air crew staffing requirements for four C-9A AE aircraft based in the European theater. We determined the number of flying hours needed to meet training and peacetime transportation requirements. We analyzed routine missions and the number and types of passengers to determine alternatives to using the C-9A aircraft. Alternatives included using other military and commercial aircraft, and using TRICARE services in Europe. We obtained the hourly cost to operate a C-9A aircraft from the Air Force Reimbursement Rates contained in Air Force Instruction 65-503, "U.S. Air Force Cost and Planning Factors," Attachment 15-1, February 1998. The rate does not include air and medical crews personnel costs. We judgmentally selected 150 flights from the 13 routine missions. The judgmental sample included at least one flight a month. We selected an outbound mission and the corresponding inbound mission to determine whether any missions could be consolidated or eliminated. In May 1997, the 1066 mission was cancelled and replaced by the Tuzla 1056 mission. The 10T6 mission was not always flown because of other mission requirements. We compared the most expensive round-trip commercial airfare published on the Travelocity web site, as of August 1998, to the DoD Standard Reimbursement Rate for the C-9A aircraft as of February 1998.

Use of Computer-Processed Data. We relied on the Automated Patient Evacuation System, which reports the number and category of patients transported by the AE system. We did not validate the database because the information was used for scope purposes and was not used in arriving at our conclusion.

Audit Type, Dates, and Standards. We performed this program audit from April through September 1998. The audit was made in accordance with auditing standards issued by the Comptroller General of the United States, as implemented by the Inspector General, DoD.

Contacts During the Audit. We visited or contacted individuals and organizations within DoD. Further details are available upon request.

Appendix B. Summary of Prior Coverage

Four audits of the C-9A AE system have been completed in the past 5 years. The Inspector General, DoD, issued three reports and the Air Force Audit Agency issued one report.

Inspector General, DoD

Inspector General, DoD, Report No. 97-192, "European Theater C-9A Aircraft Flying Hour Program," July 18, 1997.

Inspector General, DoD, Report No. 97-143, "Followup Audit of the Aeromedical Evacuation System," May 19, 1997.

Inspector General, DoD, Report No. 95-225, "Aeromedical Evacuation System," June 9, 1995.

Air Force

Air Force Audit Agency, Report No. 93496017, "Management of C-9A Aircraft Aeromedical Evacuation Operations and Training, 374th Airlift Wing, Yokota Air Base, Japan (Revised)," March 15, 1996.

Appendix C. April 27, 1998, European C-9A Schedule

Table C-1. Schedule by Destination

Destination	Mission Number	Day Flown
Lajes, Azores	1064	Thursday
Tuzla, Bosnia	1056	Tuesday
Souda Bay, Crete	10S3	Sunday
	10S4	Monday
	10T6	Thursday
Cairo, Egypt	10S4	Monday
Mildenhall, England	1062	Tuesday
	1057	Friday
Ramstein, Germany	10T4	Sunday
	10S3*	Sunday
	1061* and 10S4	Monday
	1062 and 1056*	Tuesday
	1063* and 10T5*	Wednesday
	1064* and 10T6	Thursday
	1065 and 1057*	Friday
	10T3*	Saturday
Aviano, Italy	10T4	Sunday
	1062	Tuesday
	10T5	Wednesday
	10T3	Saturday
Naples, Italy	1061	Monday
	1063	Wednesday
	1065	Friday
Pisa, Italy	1063	Wednesday
	1057	Friday

*Originating flights.

Table C-1. Schedule by Destination (cont'd)

Destination	Mission Number	Day Flown
Villafranca, Italy	1063	Wednesday
	1057	Friday
Olbia, Sardinia	1061	Monday
	1065	Friday
Al Kharj, Saudi Arabia	10S3	Sunday
	10S4*	Monday
Sigonella, Sicily	10S3	Sunday
	1061	Monday
	1063	Wednesday
	10T6	Thursday
	1065	Friday
Rota, Spain	1061	Monday
	1062*	Tuesday
	1064	Thursday
	1064	Thursday
	1065*	Friday
Cigli, Turkey	10T4	Sunday
	10T5	Wednesday
	10T6	Thursday
	10T3	Saturday
Incirlik, Turkey	10T4*	Sunday
	10T5	Wednesday
	10T6*	Thursday
	10T3	Saturday

*Originating flights.

Table C-2. Schedule by Mission Number

Mission Number	Day Flown	Stops
10S3[1]	Sunday	Ramstein Sigonella Souda Bay Al Kharj
10S4[1]	Monday	Al Kharj Cairo Souda Bay Ramstein
10T3[1]	Saturday	Ramstein Aviano Cigli Incirlik
10T4[1]	Sunday	Incirlik Cigli Aviano Ramstein
10T5[1]	Wednesday	Ramstein Aviano Cigli Incirlik
10T6[1]	Thursday	Incirlik Cigli Souda Bay Sigonella Ramstein
1061[1]	Monday	Ramstein Sigonella Olbia Naples Rota

[1]One-way mission.

Table C-2. Schedule by Mission Number (cont'd)

Mission Number	Day Flown	Stops
1062[1]	Tuesday	Rota Aviano Ramstein Mildenhall Ramstein
1064[1]	Thursday	Ramstein Rota Lajes Rota
1065[1]	Friday	Rota Naples Sigonella Olbia Ramstein
1056[2]	Tuesday	Ramstein Tuzla Ramstein
1057[2]	Friday	Ramstein Pisa Villafranca Mildenhall Ramstein
1063[2]	Wednesday	Ramstein Naples Sigonella Pisa Villafranca Ramstein

[1]One-way mission.
[2]Round-trip mission.

Appendix D. Report Distribution

Office of the Secretary of Defense

Under Secretary of Defense (Comptroller)
  Deputy Chief Financial Officer
  Deputy Comptroller (Program/Budget)
Assistant Secretary of Defense (Health Affairs)
Assistant Secretary of Defense (Public Affairs)
Director, Defense Logistics Studies Information Exchange

Joint Staff

Director, Joint Staff

Department of the Army

Auditor General, Department of the Army

Department of the Navy

Assistant Secretary of the Navy (Financial Management and Comptroller)
Auditor General, Department of the Navy

Department of the Air Force

Assistant Secretary of the Air Force (Financial Management and Comptroller)
Commander, U.S. Air Forces in Europe
Auditor General, Department of the Air Force

Unified Commands

Commander in Chief, U.S. European Command
Commander in Chief, U.S. Transportation Command

Other Defense Organizations

Director, Defense Contract Audit Agency
Director, Defense Logistics Agency
Director, National Security Agency
    Inspector General, National Security Agency
Inspector General, Defense Intelligence Agency

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General Accounting Office
    National Security and International Affairs Division
        Technical Information Center
    Health, Education and Human Services

Congressional Committees and Subcommittees, Chairman and Ranking Minority Member

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Senate Subcommittee on Defense, Committee on Appropriations
Senate Committee on Armed Services
Senate Committee on Governmental Affairs
House Committee on Appropriations
House Subcommittee on Defense, Committee on Appropriations
House Committee on Armed Services
House Committee on Government Reform
House Subcommittee on Government Management, Information, and Technology, Committee on Government Reform
House Subcommittee on National Security, Veterans Affairs, and International Relations, Committee on Government Reform

Assistant Secretary of Defense (Health Affairs) Comments

THE ASSISTANT SECRETARY OF DEFENSE
WASHINGTON, DC 20301-1200

HEALTH AFFAIRS

15 MAR 1999

MEMORANDUM FOR DEPARTMENT OF DEFENSE INSPECTOR GENERAL,
ASSISTANT INSPECTOR GENERAL FOR AUDITING

SUBJECT: Report on the Follow-up Audit of the European Theater C-9A Aircraft Flying Hour Program (Project No. 8LF-5019)

Thank you for the opportunity to review and provide comments on your draft report concerning the follow-up audit of the European Theater C-9A aircraft flying hour program. Following are my comments on your report.

I have concerns about recommendation number one to reduce the C-9A flying hour reimbursement to the Air Force by $1.43 million annually or $8.6 million for the next six years. The inspection team used $2018 per flying hour to calculate this estimated savings. However, this reimbursement rate includes logistics costs that must be paid whether the aircraft flies or not. If the more appropriate reimbursement rate of $807 per flying hour (includes fuel cost and consumable supplies) is used, the cost savings ($573K annually or $3.4 million in six years) is much less significant. Also, this reduction in flying hours could lead to increased temporary duty (TDY) costs and increased lost duty time, further reducing cost savings. Finally, a Program Decision Memorandum moves funding for C-9A operations from the Defense Health Program (DHP) to the Air Force in FY 2001, so the DHP cost savings cannot be calculated for six years, making the cost savings truly insignificant.

I also have concerns about recommendation number two to establish a flying hour program of 4,250 hours for the C-9A aircraft. The inspection report states that the 4,250 flying hours is based on a Composite Absorption Analysis Model (CAAM) flying training analysis. However, the Air Force Air Mobility Command has since stated that the CAAM analysis states that the true training requirement is 35 flying hours per month per pilot. With 12 ½ flying crews, the training requirement is really 5,250. Therefore, the inspection report understates the flying hours required by 1000 hours.

Based on my concerns, I recommend the "Report on the Follow-up Audit of the European Theater C-9A Aircraft Flying Hour Program" be changed to state that no change in C-9A flying hours is required. My point of contact for this project is Lieutenant Colonel Gary Corrick. He can be reached at (703) 681-1711 or via email at gary.corrick@ha.osd.mil.

Dr. Sue Bailey

Final Report Reference

Revised

Renumbered as Recommendation 3.

Department of the Air Force Comments

Final Report Reference

DEPARTMENT OF THE AIR FORCE
HEADQUARTERS UNITED STATES AIR FORCE
WASHINGTON, DC

JAN 26 1999

MEMORANDUM FOR ASSISTANT INSPECTOR GENERAL FOR AUDITING
OFFICE OF THE INSPECTOR GENERAL
DEPARTMENT OF DEFENSE

FROM: HQ USAF/SG
110 Luke Avenue, Room 400
Bolling AFB, DC 20332-7050

SUBJECT: DoDIG Draft Report, Follow-up Audit of the European Theater C-9A Aircraft Flying Hour Program, 24 November 1998 (Project No. 8LF-5019)

This is in reply to your memorandum requesting the Assistant Secretary of the Air Force (Financial Management and Comptroller) to provide Air Force comments on the subject report.

Revised

Recommendation 1: Reduce the C-9A flying hour reimbursement to the Air Force by $1.43 million annually ($8.6 million for the FYs 1999 through 2004 Future Years Defense Program) and use the funds for other valid health care needs. **NONCONCUR.**

1. The DoDIG audit report overestimates the potential savings of reducing the C-9A Flying Hour Program (FHP) by 710 hours. The DoDIG team used the DoD reimbursable rate of $2,018 per flying hour to calculate the estimated savings. The DoD reimbursable rate includes sunk costs that would be incurred regardless of the hours being flown. It is more accurate to use the variable cost (approximately $800 per flying hour). Using the more accurate variable cost decreases savings from $8.6M to $3.4M for six years. Additionally, the DoDIG estimated savings amount fails to consider increased TDY costs, lost duty time from home station, and cost of commercial transportation.

2. The impact of significantly reducing the FHP is a cost-shifting mechanism from the FHP to EUCOM medical treatment facilities (MTFs) or the member's unit. The MTFs or unit will incur additional TDY/per diem costs. The member's unit will incur an increase of lost duty time. The 710-hour reduction in the FHP, requiring cuts to Turkey and Italy missions, would increase TDY expenses by $284K annually. The increased TDY cost further reduces the overall Defense Health Program (DHP) savings to $1.7M over six years.

3. The projected savings to DHP money are scheduled out through FY 2004. This projection ignores the Program Decision Memorandum I that moves funding for C-9A operations from the DHP to the line of the Air Force in FY 2001. Any savings that could be recovered by the DHP would be prior to FY 2001. Total estimated savings that could be retained

Final Report Reference

by the DHP would be at the most $425K. (No saving could be realized once the cost of alternative transportation and lost duty time is factored in.)

Recommendation 2: Establish an FHP of 4,250 hours for the C-9A Aeromedical Evacuation aircraft. **NONCONCUR**

Renumbered as Recommendation 3.

1. Recommend no reduction of flying hours for the European Theater C9-A. The commander USAFE is the executive agent for USCINCEUR for the European Theater Aeromedical Evacuation (AE) system. His primary focus is to ensure a viable AE system without degrading force readiness or quality of life for the more than 200,000 active duty, US civilians and their dependents stationed in Europe. Quality of life is one of the highest priorities in DoD. It directly affects readiness, retention, military values, family life, morale, and mission accomplishment. I am concerned that the proposed 710 flying hour cut in the AE system could have devastating long-term effects on USEUCOM's peacetime medical care system and wartime medical readiness posture.

2. Page 4, Training Requirements, line 7: In July 1998 the Air Mobility Command official who is in charge of the Composite Absorption Analysis Model (CAAM) was on TDY and can not verify the statement "there is no impact to the 75th Airlift Squadron's training requirement." The CAAM was run on 14 January 1999 with no change in assumptions. These assumptions are consistent with the DoDIG audit and produced a training requirement for the 75th Airlift Squadron of 35 flying hours per month per pilot. The 12 ½ crews would then require a 5,250 flying hours a year. These hours are higher than the current FY99 flying hour program by 290 flying hours. I recommend that the current flying hour program for USAFE not be reduced.

Final unchanged from draft

I nonconcur with the DoDIG Audit. USAFE cannot realize any dollar savings or flying hour reduction. I request the auditors validate their numbers in light of the above findings. My POC for this action is Ms. Nancy Jeanne Rosenberg, HQ USAF/SGMC, (202) 767-5426/5706, Fax (202) 767-5053, or e-mail: nancy-jeanne.rosenberg@usafsg.bolling.af.mil.

CHARLES H. ROADMAN II
Lieutenant General, USAF, MC
Surgeon General

cc:
SAF/FMPF
OASD(HA)/HB&P
USAFE/CC/SG
AMC/CC/SG
TRANSCOM/CC/SG
HQ USAF/SGXR/SGMC

Audit Team Members

The Readiness and Logistics Support Directorate, Office of the Assistant Inspector General for Auditing, DoD, prepared this report.

Shelton R. Young
Raymond D. Kidd
Michael A. Joseph
Michael F. Yourey
Scott J. Grady
Suzanne M. Hutcherson
Christine S. Bowles
Danny O. Hatten
Elmer J. Smith

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Inspector General, Department of Defense
400 Army Navy Drive (Room 801)
Arlington, VA 22202-2884

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